Food and Drug Administration
Center for Food Safety and Applied Nutrition
Office of Special Nutritionals

ARMS#

13336

4 - ER URGENT

(1)

PAYMENT ARRANGEMENTS [redacted] | NAME & DAYTIME TELEPHONE # | TAX I.D NO. [redacted]

DATE 01/29/1999 | TIME OF REGIST 10:24 | DAY OF THE WEEK S M T W T F S | ACCT # [redacted] | UNIT RCD# [redacted] | MR # [redacted]

PT NAME [redacted] | DOB [redacted] | AGE 47Y | SEX F

PATIENT ADDRESS [redacted] | PT PHONE [redacted]

ADM-IC PHYS [redacted] | PV PH [redacted] PHYSICIAN NOT CHOSEN | RE PH [redacted] PHYSICIAN NOT CHOSEN

PRIM INS [redacted] | RESP PARTY [redacted]

CHIEF COMPLAINT LEGS AND ARMS NUMB/ (L) arm dull pain/shaky | PREV. REG DATE 01/28/98 [redacted]

ALLERGIES NKA | LMP 1-1-99

CURRENT MEDICATIONS None | WT 145lb

TETANUS IMMUNIZAT ☐ CURRENT ☐ NOT CURRENT ☐ UNKNOWN ☐ INSTRUCTED TO UPDATE | T 98.8 | P 77 | R 20 | BP 171/81 | LYING BP P | SITTING BP P | STANDING BP P | VISUAL ACUITY OD ___ OS ___ OU ___ ☐ CORRECTED ☐ UNCORRECTED

TIME: [11:30] ROOM NO. [redacted] ☐ SMOKER ☒ NON-SMOKER BCP ☐ Yes ☒ No

Pt C/O b.E feeling numb last noc, hands felt tingly + weak. Doesn't feel stable when ambulating, pain on (L) hip — Pt states that there's a hx in the family of hardening of the arteries [redacted]

M.D. ASSESSMENT TIME: [ ]

[illegible handwritten physician notes]

P.H. [illegible]

F.H. [illegible] heart [illegible]

P.E.

DICTATED: ☒ YES ☐ NO

DIAGNOSIS: [illegible] | ICD 9

leg pain etiology unknown [redacted]

PLAN:

f/u PCP

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02/17-19/1999
MMA MMA

ATTACHMENT #3.1

TREATMENT ORDERS/MEDS/DISCHARGE PLANNING

advil 600 [illegible]

000002

REFERRALS [redacted]

PHYSICIAN SIGNATURE X [redacted]

I HAVE RECEIVED AND UNDERSTAND THE ABOVE INSTRUCTIONS. ☐ SEE DISCHARGE INSTRUCTIONS SHEET

PT/SO SIGNATURE X

CALL BACK
☐ Improving ☐ Complian
☐ XR/Lab/EKG Disc.
☐ Referral Disc.
☐ Instr: CB if ? or NI
☐ Cont. ABX until gone
☐ Left mess to CB

SPLINTS
☐ Ace
☐ Air/Roc
☐ Robt. Jones
☐ Finger ☐ Thumb Spica
☐ Buddy Tape
☐ Post-op shoe
☐ Knee Immob.
☐ Univ. ☐ Volar
☐ Sling ☐ Crutches
☐ Rib Belt

LABS
☐ CBC ☐ UA
☐ Urine Preg
☐ Mono ☐ Chem 20
☐ C & S
☐ Strep ☐ Pos ☐ Neg

SIGNATURE

PROCEDURES
☐ EKG ☐ Monitor
☐ Nebulizer ☐ PF
☐ O_2 L/min
☐ Oxim O_2 Sa

X-RAYS

R

☐ Shielded ☐ Films Sent
Pregnant ☐ Yes ☐ No

SIGNATURE

RECORD

[redacted] ACCT: [redacted]

1/29/99

Please refer to the written portion of the [redacted] record.

CC: Legs and arms burn.

HPI: The patient is a 47-year-old female who comes in with a 24-hour history of an altered sensation in her upper legs. The patient states that when she walks they feel like they may not be "stable". She has not fallen down or actually ran into anything. The patient complains of associated pain in the left hip. She states she has had left hip pain on-and-off in the past.

PMH: The patient has a history of recurrent numbness of the fingers and hands. Apparently this has been going on for several years. She was seen for the hand numbness by Dr. [redacted] and had extensive work-up. This was negative for carpal tunnel or other identifiable neurologic disease. She has no history of hypertension. No diabetes. She has never had her cholesterol checked.

FH: The patient is concerned that this may be related to decreased circulation. The patient states that there is an unknown family history of circulatory problems. The patient states that her father died in his early 50's of heart disease. She states a sister died following a cholecystectomy with a mesenteric thrombosis.

SH: The patient does not smoke.

PE: An obese 47-year-old in no acute distress. The patient appears in good health. Normal gait, station and stance. Tympanic membranes are clear. Pharynx has mild erythema. Neck supple without adenopathy. Chest is clear. Abdomen soft. The patient does not have pedal edema. Dorsalis pedis and posterior tibial pulses are palpable and brisk in both the right and left feet. I do not palpate a popliteal pulse. Femoral pulses are 2+ and brisk bilaterally. There is good sensation of the lower extremities. Normal venous filling and deep tendon reflexes in the upper and lower extremities that are normal. the patient has full range of motion of the upper extremities. There is no tenderness of the right shoulder. The patient has tenderness in the bicipital tendon on the left side.

A: Left bicipital tendinitis.
Leg pain of unknown etiology.

P: Ibuprofen 600 mg tid. Follow up with primary care physician.

[redacted] MD

*

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MMA MMA

ATTACHMENT # 3.2

PT TYPE [redacted] **NURSE** [redacted]

RM / BED # [redacted]

DATE	01/30/1999
TIME OF REGIST	07:21
DAY OF THE WEEK	S M T W T F S
ACCT	[redacted]
UNIT RCD #	[redacted]
MR #	
PT NAME / PATIENT ADDRESS	[redacted]
DOB	[redacted]
AGE	47Y
SEX	F
ED PHYS	[redacted]
PV PH	[redacted] PHYSICIAN NOT CHOSEN
PHONE	[redacted]
PRIM INS	[redacted]
REF PHY	[redacted] PHYSICIAN NOT CHOSEN
RESP PARTY	[redacted]
CHIEF COMPLAINT	LOSS OF MUSCLE CONTROL LEFT SIDE
PREV. REG. DATE	01/29/99

ALLIGERIES ∅

CURRENT MED ∅

TETANUS STATUS

HISTORY & PHYSICAL T: 98.8 P: 86 R: 20 BP: 195/92 SaO_2: 97/RA WT:

LMP

TIME OF MD INITIAL ASSESSMENT

BY (INIT)

[redacted]

See flow

[redacted]

(1:30)
1/29 AM onset some weakness (R) leg - difficulty walking 2° to weakness. Seen @ [redacted] No abnormal strength or sensation reported. No diagnosis. Appt. 2/2 c Dr. [redacted]
03:30 this AM couldn't stand on (L) leg 2° to weakness. Some numbness both arms 2 days ago. Some numbness still present (R) arm.
No trauma
ROS. ⊖ fever ⊖ visual changes ⊖ neck pain (cervical st - 2 weeks ago - "slept wrong"). ⊖ CP ⊖ SOB ⊖ HA ⊖ abd p ⊖ M/H
PMH - Tonsils
⊕ smoke freq. ETOH.
⊕ fam hx of strokes.

- [x] CBC
  - [ ] Man Diff
- [ ] Sed Rate
- [ ] PT
- [ ] PTT
- [ ] Lipase
- [ ] Amylase
- [ ] Beta HCG
  - [ ] Qual
  - [ ] Quant
- [ ] Lactate
- [x] Sodium
- [x] Potassium
- [x] Chloride
- [x] CO_2
- [x] Glucose
- [x] BUN
- [x] Creatine
- [ ] Uric Acid
- [ ] Magnesium
- [ ] Protein
- [ ] Albumin
- [ ] Calcium
- [ ] Phosphorus
- [ ] Cholesterol
- [ ] Bili-Tot
- [ ] Bili-Conj
- [ ] Alk Phos
- [ ] LDH
- [ ] AST
- [ ] ALT
- [ ] GGT
- [ ] CK
  - [ ] MB
- [ ] Troponin
- [ ] ISO
- [ ] TSH
- [ ] UA w/Micro
  - [ ] Dip
- [ ] Urine Cult

- [ ] Drug Screen
  - [ ] Urine
  - [ ] Blood
- [ ] Type/Cross
- [ ] Type/Screen
- [ ] Type/ Hold
- [ ] Rhogam
- [ ] Mono
- [ ] Blood Cult
- [ ] GC/Chlam
- [ ] Rapid Strep
- [ ] Culture
- [ ] CSF w/Cult
- [ ] CSF Studies
- [ ] ABG on ____
- [ ] CBG on ____
- [ ] EKG

X-RAYS
- [ ] Chest
  - [ ] Port
- [ ] C-Spine
  - [ ] Cross Table
- [ ] Flat Plate / [redacted] right (ABD)
- [x] Head 852
- [ ] Abd

DICTATED: [x] Yes [ ] No

TIME	TREATMENT ORDERS	TIME	
	Admit to Dr. [redacted]		
			[ ] STANDING ORDERS

DIAGNOSIS: Cerebral vascular accident

DISCHARGE TIME | **DISCHARGE INSTRUCTIONS** | [ ] ADMIT TO DOCTOR:

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MMA MMA

ATTACHMENT #4.20

F.U. Appt | Return to Work/School

I HAVE RECEIVED AND UNDERSTAND THE ABOVE INSTRUCTIONS: | [ ] SEE DISCHARGE INSTRUCTIONS SHEET

PHYSICIAN SIGNATURE [redacted] | PT/SO SIGNATURE X

[redacted] **000004**

EMERGENCY DEPARTMENT RECORD

MEDICAL RECORDS

PG ____ OF ____

DATE 1-30-99 TIME 0725 ☐ EMERGENT ☐ URGENT ☐ NON-URGENT ☐ FOLLOW-UP ☐ FAST TRACK ETA SCENE Dr [redacted] RESCUE # RM/BED #

PATIENT NAME: [redacted] AGE 47 ☐ M ☒ F ED MD. PVT MD (None) MODE OF ARRIVAL ☐ Rescue/Amb. ☐ Wheelchair ☐ Ambulatory ☐ Air ☐ Carried

CHIEF CO [redacted]

HISTORY (L) sided weakness 2+ days
1st time episode of this nature

TRIAGE / PRE-HOSPITAL
TIME: ____ GCS: E ____ V ____ M ____ Tot ____ RTS ____
RESP. ____
CARDIO ____ CRT ____
NEURO ____
SKIN ____
MUSC - SKEL ____
☐ ET ☐ O_2 ____ ☐ CPR ☐ SPINAL PREC. ☐ SPLINT ☐ ICE
☐ IV ____ ☐ ELEVATE ☐ DRESSING ☐ OTHER ____
TRIAGE NURSE X ____

WT ☐ Stated ☐ Estimated ☐ Weighed

EXPOSURES TO INFECTIOUS DISEASES: ☐ Chicken Pox ☐ TB ☐ Other ☐ Pertussis ☐ Measles ☐ No Known Exposure

TETANUS: ☐ Current ☐ Not Current ☐ Unknown LOT #

IMMUNIZATIONS ☐ Current ☐ Not Current, Info Given

RESTRAINED ☐ YES ☐ NO ☐ UNK
HELMET ☐ YES ☐ NO ☐ UNK
AIRBAG DEPLOYED ☐ YES ☐ NO ☐ UNK
WORK RELATED ☐ YES ☐ NO ☐ UNK

☐ REPORTABLE CASE DATE TIME
AGENCY:

ALLERGIES Ø

CURRENT MEDICATIONS Ø

PMH healthy

ASSESSMENT

RESP	CARDIO	NEURO	EENT	VISUAL ACUITY	GI	GU	GYN	PREGNANT	SKIN	MUSC-SKEL	PSY-SOC	TCH / LEARN
				OD ____ OS ____ OU ____				☐ DENIES ☐ Y ☐ UNKNOWN LMP ____ EDC ____				

PERL Alert, pink, pleasant & cooperative
Sl. (L) sided weakness in comparison to (R)
(L) (+) pedal pulse - cool to touch

TIME	TEMP	P	R	BP	SaO_2 / O_2
0730	98.8	86	20	145/90	97/RA
0800		93	17	136/82	
1030		100	18	143/84	/
1280		94	17	138/84	98/RA
				/	
				/	/

TIME	MEDICATION / DOSE	ROUTE / SITE	INIT

TIME	IV FLUID / AMT / MEDICATION ADDED	RATE / HR	SIZE	SITE	STARTED BY	Time Dc'd	Amt Infused	Dc'd By

TIME	PROBLEMS / CHANGES / INTERVENTIONS	TIME	PATIENT RESPONSE / EVALUATION
0730	2 days of ↑ weakness / heaviness. Denies HA, denies CP or any other unusual pain. No recent illness. Pt. fell few times last night due to leg numbness.		
0809	weekend. Observe closely. Dr [redacted] in to evaluate		
0900	LABS, X-ray pending. Resp. effort WNL		
	Remain alert for CT		
1030	No change - NPO for CT		
1120	VS stable. NPO. No ↑ weakness		
1230	Dr [redacted] in - orders.		
1330	Upstairs per orders - Stable, no mentation changes.		

CALL	ARRIVE	NAME / TITLE	CALL	ARRIVE	NAME / TITLE

INITIALS	SIGNATURE / TITLE	INITIALS	SIGNATURE / TITLE
[redacted]			

☐ SEE ADDENDUM ED FLOW SHEET

DISCHARGE ASSESSMENT: TIME 1330
LOC: ☒ Alert ☐ ____ RESP: ☐ Unlabored ☐ ____
SKIN: ☐ Pink, Warm, Dry ☐ [redacted]
☐ Dchg ☐ AMA ☐ Admit ____
Report given to: ____
☐ Verbal ☐ Written instructions given to ____
☐ Patient / SO verbalized understanding
CONDITION ON DISCHARGE / TRANSFER:
☐ Satisfactory ☐ Fair ☐ Serious ☐ Critical ☐ Expired
DISCHARGE MODE:
☐ Ambulatory ☐ Crutches ☒ Wheelchair ☐ Stretcher ☐ Carried
Accom By: [redacted]

PATIENT BELONGINGS — BAG — ON PT. — NONE

	BAG	ON PT.	NONE
Clothing ____	☐	☐	☐
Wallet / Purse ____	☐	☐	☐
Money ____	☐	☐	☐
Jewelry ____	☐	☐	☐
Glasses ____	☐	☐	☐
Dentures ____	☐	☐	☐
____	☐	☐	☐

DISPOSITION: ☐ Not Disrobed ☐ Patient ☐ Family ☐ Security ☐ SEE BELONGINGS LIST ☐ Soc. Svcs.

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MMA mmA

ATTACHMENT # 4.23

[redacted] COPY/MED REC./COPY

PATIENT: [redacted]
DOCTOR: [redacted]
DATE: JANUARY 30, 1999 07:21

CHIEF COMPLAINT(s): Left sided weakness and difficulty walking.

HPI: The patient is a 47-year-old female who reports that about 1:30 in the morning on 1/29/99 she had the onset of weakness in her left leg. She has had persistent weakness in the left leg and lesser so in the left arm since that time. She reports difficulty walking secondary to this weakness.

She was seen at [redacted] yesterday where no abnormal strength or sensory abnormality was reported. A diagnosis was not established. She has an appointment with Dr. [redacted] on 2/2/99.

At 3:30 this morning the problem seemed to be even worse and she could not stand at all secondary to weakness in the left leg. She has also had some numbness in both arms two days ago and still has some numbness presents in the left arm. She denies any trauma.

ROS: She denies fever, visual changes or neck pain. She did have some neck soreness two weeks ago that happened after she "slept wrong". She denies chest pain, shortness of breath, headache, abdominal pain, melena or hematochezia. No other system complaints reported.

PMH: Remarkable for tonsillectomy.

ALLERGIES/MEDS: None.

SH/FH: She denies smoking. She does report frequent alcohol use. FH-Negative for cerebral vascular accidents but positive for coronary artery disease.

PHYSICAL EXAM:

VITAL SIGNS: Temp 98.8°, pulse 86, respirations 20, BP 195/92 rechecked later at 138/84. Pulse oximeter on room air normal at 97%.

She appears to be alert and in no distress.

HEENT: PERRL, full EOMS.

NECK: Carotids are equal and the neck is supple and nontender.

LUNGS: Clear and breath sounds are equal. There is no costovertebral angle tenderness.

HEART: S1, S2 with a slight 1/6 systolic murmur.

ABDOMEN: Bowel sounds are positive. The abdomen is soft and nontender.

SKIN: Dry without rashes.

NEURO: Alert and oriented x 3. Cranial nerves III-XII are intact. Strength in the left leg seems to be diminished slightly. Sensation is symmetrical. Reflexes are 2+ and equal. The patient has poor coordination of her left leg and cannot walk secondary to this.

PATIENT: [redacted] ADMIT [redacted]
DOCTOR:
PAGE: 2

DIAGNOSTIC STUDIES: Chem 7 is unremarkable. CBC white blood cell count is 7.5, Hct 42.6. CT of the brain demonstrates a 12 mm hypodense lesion in the right basal ganglia and posterior limb of the right internal capsule. This could be consistent with an acute lacunar infarct. She also has a 5 mm hypodense lesion in the left external capsule, again a possible small lacunar infarct.

TREATMENT/ANALYSIS: The patient presents to the emergency room with left sided weakness that appears to be consistent with a cerebral vascular accident. The patient does not show any evidence for trauma. She is not anemic and her electrolytes are good. There is no evidence of bleeding in the brain.

Her case was reviewed with Dr. [redacted] of neurology. Dr. [redacted] will admit the patient to the hospital for further care. She is presently stable.

FINAL DIAGNOSIS: **Cerebral vascular accident.**

[redacted] M.D.

[redacted]
January 30, 1999

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02/17-19/1999
MMA MmA
ATTACHMENT # 4.22